State of New Jersey Department of Labor DIVISION OF WORKERS' COMPENSATION Office of Special Compensation Funds	**SECOND INJURY FUND VERIFIED PETITION** SCF-161 (R 10-03)	C.P. No(s): D.O.:

PETITIONER	
	Social Security Number:
	Name:
	Address (including county):

PETITIONER ATTY	
	Federal Employer Identification Number:
	Name
	Address: **Phone:**

RESPONDENT	
	Name:
	Address (Including county):

INSURANCE CARRIER	
	Name (Indicate If Not Covered Or Self-Insured):
	Address:

TO THE COMMISSIONER OF LABOR OF THE STATE OF NEW JERSEY:

Petitioner hereby alleges eligibility for benefits from the Second Injury Fund pursuant to N.J.S.A. 34:15-95 et seq., and respectfully states the following:

Date of Birth:	**Age:**	**Sex:**	**Marital Status:**	**Number of Dependents:** *(If one or more, see Page 3)*
Educational Background:			**Special Skills:**	

Employment History: (List all former employers, dates of employment and job descriptions; use additional sheets as required.

Pre-Existing Medical Conditions: (List physical and/or psychiatric conditions which pre-existed your last compensable accident of exposure or dates of onset)

Description of Last Compensable Accident or Occupational Disease Exposure:

Brief Description of Treatment Received For Last Compensable Injury or Disease:

Current Medical Conditions: (List physical and/or psychiatric conditions which have been caused, aggravated or accelerated by the last compensable accident or exposure or dates of onset

If you have initiated an action at law against a third party for all or any portion of the injury or disease you sustained as a result of your last compensable injury or disease, please provide the name and address of such third party, the status of your action, and, if concluded, the gross settlement amount of such action.

Provide below your current monthly income from the following sources:		
Social Security Retirement:	$	If receiving Social Security retirement benefits, provide the date of your entitlement:
Social Security Disability:	$	If receiving Social Security Disability benefits, provide the date of your entitlement:
Auxiliary Social Security:	$	If receiving Auxiliary Social Security, provide the date of your entitlement:
Black Lung Benefits:	$	If receiving Black Lung benefits, provide the date of your entitlement:
Retirement Pension Benefits:	$	If receiving Retirement Pension, provide the date you began receiving same:
Disability Retirement Benefits:	$	If receiving Disability Retirement Benefits, provide the date you began receiving same:
Veterans Administration Benefits:	$	If receiving Veterans Administration Benefits, provide the date you began receiving same:
Temporary Disability Benefits:	$	If receiving Temporary Disability Benefits, provide the dates of such benefits:

Please provide the names and dates of birth of all dependents cited on Page 1.

Prior Compensation Awards: (Please list all claim petition numbers, dates of injury or last exposure, percentages of disability and body parts and attach any copies of Judgments in your possession:

I believe that I am totally and permanently disabled as the result of a combination of my pre-existing physical and/or psychiatric conditions and my last compensable injury or disease. Further, I believe that the exclusionary provisions of N.J.S.A. 34:15-95 do not apply to my case. Accordingly, I hereby petition for Second Injury Fund benefits under the provisions of N.J.S.A. 34:15-95, *et seq.* Further, I authorize the release of information concerning benefits and/or wages by the Social Security Administration, insurance carriers, employers and/or union organizations to the Office of Special Compensation Funds for investigation of matters related to this petition and any resulting benefits that I may receive. Therefore I hereby, on my oath, affirm that I have read the foregoing and am familiar with the contents thereof and that the matters set forth are true to the best of my knowledge and belief.

_____ _____

(Petitioner Signature) *(Date)*

STATE OF NEW JERSEY

COUNTY OF _____ **SS:**

Subscribed and sworn before me on this _____ **day of**

_____, _____.

_____

The Privacy Act, 5 U.S.C. §522a, the Social Security Act, 42 U.S.C. § 405, and N.J.S.A. 34:15-1 *et seq.* authorize the Division of Workers' Compensation to request that the Petitioner supply the Division with his or her Social Security number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.

NOTE: Attach copies of all treating physicians' reports in your possession and proposed expert witnesses' reports. Pursuant to Division Rules, do not attach hospital records, except excerpts.